F

MRN#: SM02706496
Patient: GUTIERREZ,CYNTHIA
Report Status: Signed
Documented By: LAUST001
Documented Date: 02/25/15 0742

Account#: SV0083448563
Report Type: EDPHYRPT
Report Mnemonic: PHY.ER
Report#: 0225-0094
Facility: NSM

Emergency Department Report

ADDENDUM

02/26/15

Addendum: Lauterbach,Stewart A on 2/26/15 @ 11:10

I failed to note in the note below that this patient immediately after the patient was intubated, a large piece of food was aspirated from the ET tube. This was removed by Dan, our respiratory therapist. I question if she could have had an aspiration leading to hypoxia, and the collapse.

This Addendum is not considered FINAL until Signed by a Physician

Authenticated By:
<Electronically signed by Stewart A Lauterbach MD> 02/26/15 1113

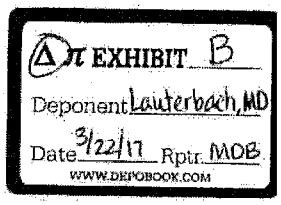
Lauterbach, Stewart A MD

cc:

History of Present Illness

HPI

Service date
2/25/15
Time Seen by MD: 07:41
Chief complaint: full arrest, refer to code record
This is a 33y/o female that was seen here overnight in the ER, discharged this morning. She was sitting out in the waiting room when a patient's family member noticed she looked unresponsive. ER staff responded immediately and started CPR. Patient has a known history of ESRD. HPI is otherwise limited secondary to patient condition.
Location: hospital
Onset/Duration/Timing: started approximately - 0720 this morning
Related symptoms: : - unknown



Past Medical History

Coded Allergies:
No Known Allergies (Unverified , 2/25/15)
per huisband, no known allergies

Active Scripts
Hydrocodone Bit/Acetaminophen (Norco 10-325 Tablet)10 Mg/325 Mg Tab1 Tab PO Q6HR PRN (PAIN, Moderate to Severe(4-10)) #20 TAB
Prov:Brandwene,Elliott L 2/25/15
Oxycodone Hcl/Acetaminophen (Percocet 10-325 Mg Tablet)1 Each Tablet1 Tab PO Q4HR #10 TAB
Prov:Brandwene,Elliott L 2/6/15
Hydrocodone Bit/Acetaminophen (Norco 5-325 Tablet)5 Mg/325 Mg Tab1-2 Tab PO Q6H PRN (PAIN, Moderate to Severe(4-10)) #15 TAB

Prov:Allred,Kendall S 2/1/15
Metoclopramide Hcl (Reglan)10 Mg Tab10 Mg PO ACHS #120 TAB Ref 3
Prov:Altaf,Mujeeb 1/22/15
Hydrocodone Bit/Acetaminophen (Norco 5-325 Tablet)5 Mg/325 Mg Tab1 Tab PO Q6H PRN (PAIN, Mild (1-3)) #30 TAB Ref 0
Prov:Quang,Angela M 1/16/15
Amlodipine Besylate (Norvasc)5 Mg Tab5 Mg PO DAILY 30 Days
Prov:Junck,Daniel L 1/5/15
Atorvastatin Calcium (Lipitor)20 Mg Tab20 Mg PO QPM #30 TAB Ref 0
Prov:Quang,Angela M 12/17/14
Furosemide (Lasix)80 Mg Tablet80 Mg PO DAILY #30 TAB
Prov:Altaf,Mujeeb 12/3/14
Ondansetron (Zofran Odt)4 Mg Tab.rapdis4 Mg PO BID PRN (NAUSEA/VOMITING) #10 TAB
Prov:Muller,Ridgely O 11/2/14

Reported Medications

Hydralazine Hcl 50 Mg Tablet50 Mg PO BID #120 TAB
1/13/15
Metoprolol Tartrate 100 Mg Tablet100 Mg PO BID #60 TAB
TO TAKE AM OF SURGERY
1/13/15
Brimonidine Tartrate (Brimonidine Tartrate 0.2%)5 Ml Drops1 Drop BOTH EYES TID #5 ML
6/7/14
Timolol Maleate (Timolol Maleate Ophth Soln 0.5%)10 Ml Drops1 Drop BOTH EYES BID #10 ML
6/7/14
Latanoprost 2.5 Ml Drops1 Drop BOTH EYES QPM #2.5 ML
6/7/14

Travel History

Travel and/or hospitalization outside the US in the last 30 days?
Past medical records: reviewed
Endocrine history: DM type 2, hypothyroidism
Renal history: renal failure, dialysis
Other pertinent history: chronic pain
Family history of: DM
Smoking Status: Never A Smoker
History Of Substance Abuse: No

Review of systems

ROS unobtainable due to: acuity of condition

Physical Exam

Exam

Vital signs

Initial Vital Signs

Date Time	Temp	Pulse	Resp	B/P	Pulse Ox	O2 Delivery	O2 Flow Rate	FiO2
2/25/15 08:16		116			100			100
2/25/15 08:45	97.7		14	126/63		Ventilator		

Exam limitations: clinical condition
General appearance: unresponsive, : - uremic frost
Head/ENT: atraumatic, no airway obstruction
Respiratory: lungs clear - after intubation, no spontaneous respirations
Cardiovascular: : - pulseless rhythm
Abdomen: soft, no distention
Extremities: no signs of trauma
Neurologic: unresponsive

Glasgow Coma Scale

Eye opening: 1=none
Verbal response: 1=none

Motor response: 1=no response

Data

Vital Signs

Date Time	Temp	Pulse	Resp	B/P	Pulse Ox	O2 Delivery	O2 Flow Rate	FiO2
2/25/15 08:45	97.7	88	14	126/63	100	Ventilator		40
2/25/15 08:16		116			100			100

Medications Administered

Given in ED

Medications Administered

Medications (Trade)	Dose Ordered	Sig/Sch	Start Time Stop Time	Status	Last Admin Dose Admin
Pantoprazole Sodium/Sodium Chloride (Protonix Inj/ Normal Saline)	100ml @ 10 mls/hr	Q10H	2/25/15 08:10		2/26/15 04:41 10 MLS/HR
Propofol	100ml @ 0 mls/hr	Q0M PRN	2/25/15 08:08		2/26/15 08:21 0 MLS/HR

Diagnostics & Interpretation

X-RAY (Interpreted by EP) :

Read by: Radiologist

X-RAY type: chest

# of views: 1

X-RAY positive findings: : - et low - called nurse - inc dens infilts lll, rul, rll.. stable cm, rt jug

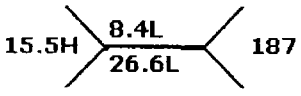
CT :

CT findings

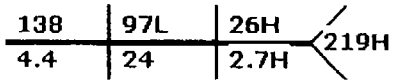
Head - negative acute

Result Diagram:

2/26/15 0614



2/26/15 0614



Lab Results

Laboratory Tests

Test	2/25/15 07:41	2/25/15 07:47	2/25/15 07:50	2/25/15 08:48
POC Glucose	200 H mg/dL (65-99)			101 H mg/dL (65-99)
WBC		12.2 H 10^3/uL (3.5-11.0)		
RBC		2.78 L 10^6/uL (3.50-5.50)		
Hgb		8.1 L g/dL (12.0-15.0)		
Hct		26.0 L % (36.0-45.0)		
MCV		93 fL (79-95)		
Plt Count		163 THD/uL (120-400)		

Manual Differential		Not Indicated		
Seg Neutrophils %		52.9 % (34-64)		
Lymphocytes %		36.3 % (19-48)		
Monocytes %		7.0 (3-9)		
Eosinophils %		2.2 % (0-7)		
Basophils %		1.6 % (0-2)		
Anisocytosis		2+		
PT		14.5 Sec. (11.9-14.8)		
INR		1.10 (0.6-1.4)		
PTT		25.8 SEC (23.0-36.3)		
Sodium		140 mmol/L (136-144)		
Potassium		4.3 mmol/L (3.6-5.1)		
Chloride		103 mmol/L (101-111)		
Carbon Dioxide		24 mmol/L (22-32)		
Anion Gap		13.0 H (3.0-11.0)		
BUN		60 H mg/dL (8-20)		
Creatinine		4.1 H mg/dL (0.40-1.00)		
Est GFR (African Amer)		16 L ml/min (>60)		
Est GFR (Non-Af Amer)		13 L ml/min (>60)		
Glucose		210 H mg/dL (65-99)		
Lactic Acid		6.5 *H mmol/L (0.5-2.2)		
Calcium		9.8 mg/dL (8.9-10.3)		
Total Bilirubin		0.6 mg/dL (0.3-1.2)		
AST		42 H IU/L (15-41)		
ALT		94 H IU/L (14-54)		
Alkaline Phosphatase		266 H IU/L (32-91)		
Rapid CK-MB (CK-2)		6.4 H ng/mL (0.6-6.3)		
Rapid Troponin I		< 0.05 ng/mL (<0.05)		
Rap B-Natriuretic Pept		> 5000 *H pg/mL (0-100)		
Total Protein		6.5 gm/dL (6.1-7.9)		
Albumin		2.9 L g/dL (3.5-4.8)		
Globulin		3.6 H gm/dL (2.3-3.5)		
ABG pH			7.29 L (7.35-7.45)	
ABG pCO2			42.8 mmHg (32-45)	
ABG pO2			328.0 H mmHg	

			(83-100)	
ABG pO2 at Pt Temp			328 H mmHG (83-100)	
ABG HCO3			20 L mmol/L (22-26)	
ABG O2 Saturation			100.0 H % (95-99)	
ABG Base Excess			-5.7 L (-2 to +2)	

Medical Decision Making

Progress Notes

Progress Note :

Date: Feb 25, 2015

Time: 07:45

Note

Dr. Kang (ICU) at bedside, he will admit pt

Medical decision making/Course

Course

This 33-year-old dialysis patient is extremely well known to us in the emergency department for numerous visits with nausea vomiting gastroparesis and also with a history of her multiple complications of diabetes was seen with nausea and vomiting last night. She was in good shape and the vomiting was brought under control and she was discharged as some many times previously. Her potassium was noted to be 4.9 in the department. She was discharged to the lobby and was apparently sitting there when she collapsed to the floor a code was called and our staff responded to the lobby to bring the patient back she's placed on a gurney and CPR started is no palpable pulses are detected she is placed in a critical care room him putting her on the gurney into the critical care room. CPR was continued she's intubated while the nurses are getting her hooked up to the monitors. On the cardiac monitor we see a narrow complex relatively bradycardic rhythm regular at perhaps 30. Given the critical nature of her dialysis port is accessed and her drugs are given via that route she's given calcium and bicarbonate based on the possibility of acute hyperkalemia. Is followed with epinephrine. On her initial ultrasound I can see valve motion within the heart but no significant wall motion. Following the epinephrine her heart rate speeds up and her contractility increases her blood pressure returns stopped and ultimately her heart rate is 150 slowly this drops back down to about 120. Her examination she is unresponsive she has the appearance of diabetes and renal failure, no pulses and agonal respiratory efforts. Dr.

Kang the intensivist is contacted and he comes down to see the patient and will admit her to the intensive care unit. The nephrologist are contacted.

Procedures

Intubation

Time of Intubation: 07:35

Reason for Intubation:

arrest

Assessed for difficult airway: Yes

Intubation Method: orotracheal

Tube size: 8.0

Medications: : - crash intubation

Tube placement confirmation: condensation in tube, equal chest rise, visualized going through cords

Intubation complications: none

Post intubation xray: position adjusted

Critical Care

Critical care time: 30-74 mins excluding procedures

Critical care time

This critical care time did not overlap with any other physicians or include procedures. During this critical care time, the patient was at high risk of life threatening or organ threatening decompensation.

Disposition

Latest vital signs

Vital Signs

	2/25/15 08:45
Temp	97.7
Pulse	88
Resp	14
B/P	126/63
Pulse Ox	100
O2 Delivery	Ventilator
FiO2	40

Impression:
Primary Impression: Cardiopulmonary arrest
Additional Impression: ESRD (end stage renal disease) on dialysis
Condition: Critical
Disposition: Admit Acute Inpt This Fac
Admit to: ICU
Admitting provider: Dr. Kang

Attestation

Documentation prepared by Arnold, Christina M , acting as medical scribe for and in the presence of Dr. Lauterbach 2/25/15 08:08

All medical record entries made by the scribe were at my direction and in my presence. I have reviewed the chart and agree that the record accurately reflects my personal performance of the history, physical exam, medical decision making, and the emergency department course for this patient. I have also personally reviewed and agree with the discharge instructions and disposition.

EMR and Dragon Attestation - this medical document was created using an electronic medical record system with Dragon computerized dictation system. Although this document has been carefully reviewed, there may still be some phonetic and typographical errors. These errors are purely typographical, due to imperfections of the software programs, and do not reflect any compromise in the patient's medical care.

Lauterbach,Stewart A — Feb 25, 2015 07:42
Arnold,Christina M SCRIBE — Feb 25, 2015 08:09

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Authenticated By:
<Electronically signed by Stewart A Lauterbach MD> 02/26/15 0938

Stewart A Lauterbach

cc: